March 30, 2017

CROSSWALK

VHA Handbook 1004.03 – Life-Sustaining Treatment Decisions: Eliciting, Documenting And Honoring Patients' Values, Goals And Preferences

- This document is intended to help VA medical facility personnel understand, at a glance, the major policy changes reflected in VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting And Honoring Patients' Values, Goals And Preferences*.

- VHA Handbook 1004.03 is part of the VHA Life-Sustaining Treatment Decisions Initiative, a national VHA quality improvement project led by the National Center for Ethics in Health Care (NCEHC). The Initiative and Handbook 1004.03 represent steps toward a culture change to ensure that our care of seriously ill Veterans is based on their goals, values, and preferences, and that documentation of life-sustaining treatment plans and orders is easy to find in the electronic record.

- VHA Handbook 1004.03 rescinds VHA Handbook 1004.3, *Do Not Resuscitate (DNR) Protocols within the Department of Veterans Affairs (VA)* Published: October 24, 2002. VHA Handbook 1004.03 also replaces paragraph 14.c.(3) of VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*.

- Only the major policy changes are reflected below. Facilities are advised to closely review VHA Handbook 1004.03 for additional details as a basis for developing consistent VAMC policy.

- A medical center memorandum template is available at http://vaww.ethics.va.gov/activities/policy.asp. We recommend that facilities use this template as a basis for developing their local policies.

- For more information about the VHA Life-Sustaining Treatment Decisions Initiative, VHA Handbook 1004.03, and related resources, please go to the following National Center for Ethics in Health Care website: vaww.ethics.va.gov/LST.asp

	VHA Handbook 1004.3 — Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA) Published: October 24, 2002 (RESCINDED BY HANDBOOK 1004.03)	VHA Handbook 1004.03 — Life-Sustaining Treatment Decisions: Eliciting, Documenting And Honoring Patients' Values, Goals And Preferences	1004.03 - Paragraph(s)
1.	Specified policy and procedures for Do Not Resuscitate Protocols only	Establishes standardized procedures for eliciting, documenting, and honoring specific decisions regarding the initiation, limitation or discontinuation of life-sustaining treatments (LST), including cardio-pulmonary resuscitation	4,5,6,7,8,9,10,11,12
2.	Did not specify requirements for a conversation with the patient/surrogate	Requires a goals of care conversation (GoCC) with the patient (or surrogate if the patient lacks decision making capacity) prior to writing LST orders, including DNAR/DNR orders	5,7
3.	Focused on DNR orders for terminally ill patients	Reflects legal and ethical standards that patients with decision-making capacity have the right to accept or decline recommended medical treatments or procedures, including LSTs – regardless of whether they have a terminal condition	2
4.	Referred to an individual incapable of making health care decisions as "incompetent patients"	Reflects legal and ethical standards differentiating patients who lack decision making capacity and patients who have been deemed incompetent as a matter of law	3
5.	Referred to the individual designated to make decisions on behalf of an incompetent patient as the "patient representative"	Replaces the term "patient representative" with the term "surrogate" and reflects legal and ethical standards that patients who lack decision-making capacity have the right to have a surrogate make decisions on their behalf based on the surrogate's understanding of the patient's values, goals, and preferences	3
6.	Specified the elements to be included in VAMC DNR protocols	Establishes national, standardized procedures for eliciting, documenting, and honoring specific decisions regarding the initiation, limitation or discontinuation of LST that must be reflected	4,5,6,7,8,9, 10,11,12,17

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		in VAMC policy on LST	
7.	Specified that VAMC policy would establish the "requirements for the DNR order itself, including who may write it, how long it will be valid and provisions for its review."	Establishes national, standardized procedures for who may write LST orders, how long LST orders will be valid and provisions for reviewing an LST plan and orders. Establishes triggering events for initiating a GoCC as a basis writing and reviewing LST plans and orders	3,5,7,9,11
8.	Permitted only senior attending or staff physicians to determine "the propriety of" and write a DNR order	Expands authorization to write LST orders — including DNAR/DNR orders — to all "practitioners" defined as "attending physician or other licensed independent practitioner (LIP). "Practitioner" also includes the following when an attending physician or other LIP has delegated to them the responsibility for conducting GoCCs and writing LST progress notes and LST orders: • physician residents • advanced practice registered nurses and physician assistants whose scope of practice agreement, or other formal delineation of job responsibility explicitly authorizes them to write LST progress notes and LST orders	3,5,7,9,11
9.	Specified that local VAMC policy would establish how long a DNR order would be valid	Mandates that patients' LST orders, including DNAR/DNR orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer) but will remain in effect unless they are modified based on a new or revised LST plan	11
10.	Specified that local VAMC policy would	Mandates that VAMCs build the local progress note title, "Life-	9, 17

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	establish requirements for flagging or otherwise highlighting the medical record to indicate the entry of a DNR order	Sustaining Treatment," linked to the national standard title, "Life-Sustaining Treatment Plan." This note title must be placed in the "Directives" progress note category so it will appear in the "Crises, Warnings, Allergies, Directives" (CWAD) postings on the CPRS cover sheet. Mandates that VAMCs set the CPRS orders tab parameters so that the LST orders on the Life-Sustaining Treatment Order Set display group defaults to the top of the Orders tab and these orders are visible to all personnel with access to CPRS. (The National Center for Ethics will provide regular support calls to clinical application coordinators for installation of these CPRS tools. For more information, see: vaww.ethics.va.gov/LST.asp)	
11.	Specified that local VAMC policy would establish requirements for the accompanying DNR progress note and who may write it	Mandates that LST plan and orders are documented in the standard LST progress note and LST orders. Expands authorization to write LST plan and orders to all "practitioners" (See #7, above)	3,5,7,9,10,11
12.	Prohibited automatic suspension of a DNR order. Required the practitioner talk to the patient who has a DNR order about whether it will be maintained during surgery, and to document the discussion/decision	Prohibits automatic suspension of a DNR order. For any proposed exception to a DNAR/DNR order for a specific procedure, the practitioner must obtain oral consent from the patient or surrogate and write orders in CPRS to specify the procedure during which CPR should be attempted in the event of a cardiopulmonary arrest. The LST order set includes a "DNR with exception" order option	5,11
13.	Required that a DNR order be "written or, at	Requires, among other things, that the delegating practitioner must	9

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	minimum, countersigned by the attending physician."	document review of the LST plan within 24 hours (or 72 hours in a Community Living Center, outpatient setting, or Home-Based Primary Care setting) and document concurrence or non-concurrence. No longer requires that the delegating practitioner rewrite the orders	
	VHA Handbook 1004.01 – Informed Consent for Clinical Treatments and Procedures	**VHA Handbook 1004.03 – Life-Sustaining Treatment Decisions: Eliciting, Documenting And Honoring Patients' Values, Goals And Preferences**	**1004.03 Paragraph(s)**
1.	14.c.(3) of Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, was the original location for policy on decisions concerning the withdrawal and withholding of life-sustaining treatment for patients who lack decision making capacity and have no surrogate. It provided facilities the option to either request the District Chief Counsel's assistance to obtain a guardian for health care to serve as the patient's surrogate or to follow the multidisciplinary committee review process	Paragraph 8 of Handbook 1004.03 replaces paragraph 14.c.(3) of VHA Handbook 1004.01. (Handbook 1004.03 maintains the option to either request the District Chief Counsel's assistance to obtain a guardian for health care to serve as the patient's surrogate or to follow the multidisciplinary committee review process. (See below for specific changes)	7,8
2.	Silent on what the emergency response should be when a patient who lacks	When a patient who lacks decision making capacity and has no surrogate presents to VA with SAPO, the practitioner must write an	7,8

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	decision making capacity and has no surrogate presents to VA with state-authorized portable orders (SAPO)	LST progress note and orders in accordance with the SAPO unless there is a reason to doubt the SAPO's validity. For these patients, the practitioner must then initiate a consult to the multidisciplinary committee within 24 hours. If, during the multidisciplinary committee review process the patient experiences an emergency, treatment will be based on the documented orders reflecting the SAPO	
3.	Required the practitioner to initiate a multidisciplinary committee review when a proposed treatment plan (for patients who lack decision making capacity and have no surrogate) included withdrawal or withholding of life-sustaining treatment	Requires the practitioner to develop a proposed LST plan and initiate a multidisciplinary committee review of the proposed plan for all high risk patients who lack decision making capacity and have no surrogate.	7,8
4.	Did not specify composition of the multidisciplinary committee	Specifies that the multidisciplinary committee must be comprised of three or more different disciplines, including one member of the facility's Ethics Consultation Service	8
5.	Did not establish timeframes for the multidisciplinary committee to document its findings and recommendations in the patient's chart	Establishes timeframes for the multidisciplinary committee to document its findings and recommendations in the patient's chart	8